

FOR STATE  
HEALTH DEPT.

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after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form DM3. Page 5 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-10262

1. DECEASED-NAME (Type or Print)	First	Middle	Lost	2a. DATE KNOWN OF ESTI- MATED	Month	Day	Year	2b. HOUR
FREDERICK L. CUSACK				<input checked="" type="checkbox"/>	4	27	1979	M
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS			
m	w	3-20-13	66 yrs.	MONTHS	DAYS	HOURS	MIN	

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH
NEW YORK	USA	QUEEN ANNE	

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during past of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
STEVENSVILLE	CHESAPEAKE AVE	PAINTER	Ret

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER
MD.	Q. ANNE	STEVENSVILLE		CHESAPEAKE AVE

14. FATHER'S NAME	First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle	Lost
DANIEL		W.	CUSACK	Lillian			CRONK

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
NO	213 124705	MAUREEN JASON ROCHESTER NY	3 yrs
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myelogenous Leukemia DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes Mellitus DUE TO, OR AS A CONSEQUENCE OF (c)			
3051 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
7 yrs			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
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21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State
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22o. I certify that I took charge of the remains described above, held on Autopsy  Inspection  Inquiry  and in my opinion death resulted from: Noturol causes  Accident  Suicide  Homicide  Undetermined manner

ACTUAL SIGNATURE *John R. Smith* M.D. CHIEF MEDICAL EXAMINER   
EXAMINER'S NAME (Type) DEPUTY MEDICAL EXAMINER   
ADDRESS (Street, city, town, or county)

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 8/30/79	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	23d. LOCATION (City or Town) Annapolis (County) Anne Arundel (State) MD.
24. FUNERAL DIRECTOR John M. Lytton	ADDRESS	25a. REC'D BY REGISTRAR MAY 2 1979	25b. REGISTRAR'S SIGNATURE <i>Victor Kennedy</i>

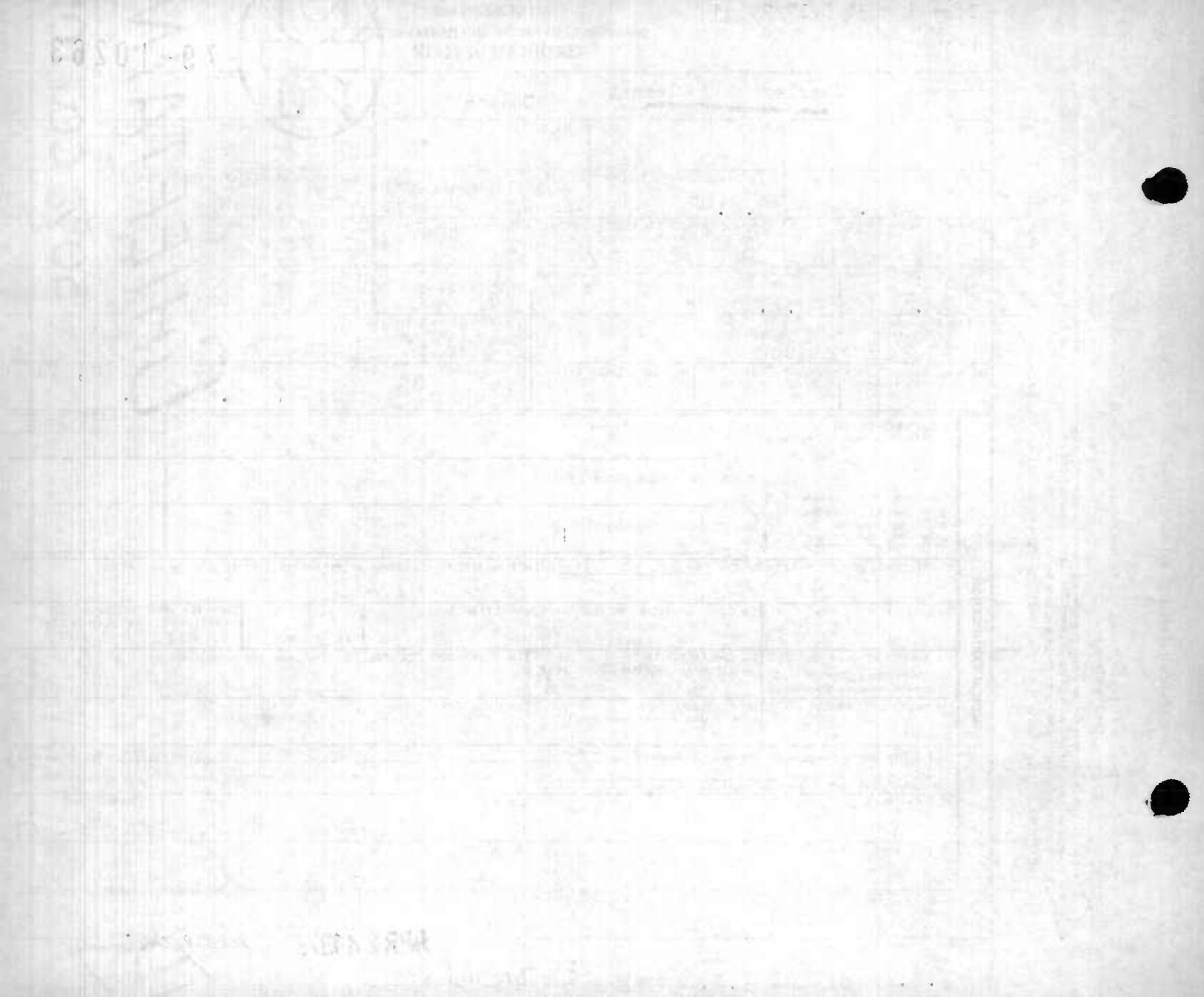


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, ~~page 3~~ should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death at the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 79-10263											
1. DECEASED NAME (TYPE OR PRINT)			FIRST Charles Clement Deaton			LAST Deaton			2a. DATE OF DEATH MONTH DAY YEAR		
3. SEX Male			4 RACE Negro			5. DATE OF BIRTH MONTH 9 / DAY 17 / YEAR 94			6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Queen Anne MD.		
10. CITY OR TOWN OF DEATH Centreville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RFD #2 Box 74			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY Q.A.			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST Richard Deaton			LAST			15. MOTHER'S MAIDEN NAME Harriett Deaton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO.			17. INFORMANT Richard Deaton			ADDRESS Wilmingt'on Del 715 E. 6th St.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>4275</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>CANCER OF THE PROSTATE</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>4-1</u> , 19 <u>79</u> , to <u>4-1</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>4-1</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE <u>R. E. Libby</u>			DEGREE <u>M.D.</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>4-18-79</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ralph E. Libby, M.D.			22e. ADDRESS P.O. Box 203 Grasonville, Md. 21638								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/7/79			23c. NAME OF CEMETERY OR CREMATORIAL Burrieville			23d. LOCATION CITY OR TOWN Centreville		
24. FUNERAL DIRECTOR NAME <u>J. P. Daugherty</u>			ADDRESS <u>P.O. Box 600 Easton, Md.</u>			24e. DATE OF REGISTRATION APR 24 1979					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG NO. 79-10264				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
Ethel Mary de le Rue						4-3-79			4	3	1979	32 <sup>nd</sup> AM				
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR					
Female			White		MONTH DAY YEAR			88			MONTHS DAYS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8.			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS					
Atlantic City, N.J.			USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Queen Anne's Co.			MONTHS HOURS MIN					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Centreville			Corsica Hills Nursing Center									Housewife				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS					
Md.			Kent		Chesterfield			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Campus Avenue					
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME										
Charles			H.		Sassee	Rosa										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.									17. INFORMANT			ADDRESS	
no			105-24-5426									Nursing Home Records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Probable Sudden Cardiac Death															Immediate	
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															(b). Atherosclerotic Cardiovascular Disease. Years	
{ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
9/9												YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE				
22a. I certify that (I) this hospital attended the deceased from September, 1977, to April 3, 1979, that (I) we last saw the deceased alive on March 4, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE			22c. DEGREE			ATTENDING PHYSICIAN			MEDICAL DIRECTOR			STAFF PHYSICIAN			22d. DATE SIGNED	
Charles P. Adams MD															April 4, 1979	
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS													
Charles P. Adams MD			Chesterfield, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY STATE				
Burial			4/5/79			Rock Creek Cemetery			Washington D.C.							
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR									25b. REGISTRAR'S SIGNATURE				
Willie Wells												APR 6 1979			John McCreedy	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM #M. 3, RETAIN PAGE 3 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 79-10265					
1 - STATE REGISTRAR			1. DECEASED NAME FIRST MIDDLE LAST						2a. DATE KNOWN OF ESTI- DEATH			2b. HOUR					
			<b>Norris B. Garrison, Sr.</b>						<input checked="" type="checkbox"/> MONTH 4 DAY 21 YEAR 79			12:45 P.M.					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD		2d. HOUR			
M		Cau		1 4 93		86 yrs.						4 2 19 79		3:00 P.M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?						8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Delaware		USA										Q.A.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY			
Sudlersville		Walls Nursing Home						Retired									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Delaware		Kent		Dover		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		937 Sunset Terrace									
14. FATHER'S NAME				LAST		15. MOTHER'S MAIDEN NAME											
Thomas				Garrison		FIRST MIDDLE LAST		Bernard									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		222-14-2199		Sarah Thompson, 937 Sunset Terr. Dover		De											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) 410- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  DUE TO, OR AS A CONSEQUENCE OF (b) ASND (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Inhalation 5 yrs.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?					
												YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												DATE SIGNED 4/6/79					
ACTUAL SIGNATURE John R. Smith, Jr.			TITLE (SPECIFY) M.D.			MEDICAL EXAMINER Centerville, Md.											
EXAMINER'S NAME (TYPE OR PRINT)																	
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial			23b. DATE 4-4-79			23c. NAME OF CEMETERY OR CREMATORIUM Odd Fellows Cemetery			23d. LOCATION CITY OR TOWN Camden, Kent, De.			COUNTY STATE					
24. FUNERAL DIRECTOR NAME Harvey J. Williamson			ADDRESS Federalsburg, Md.			25a. DATE REC'D. BY REGISTRAR APR 16 1979			25b. REGISTRAR'S SIGN Henry H. Brady								

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS OF DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET.

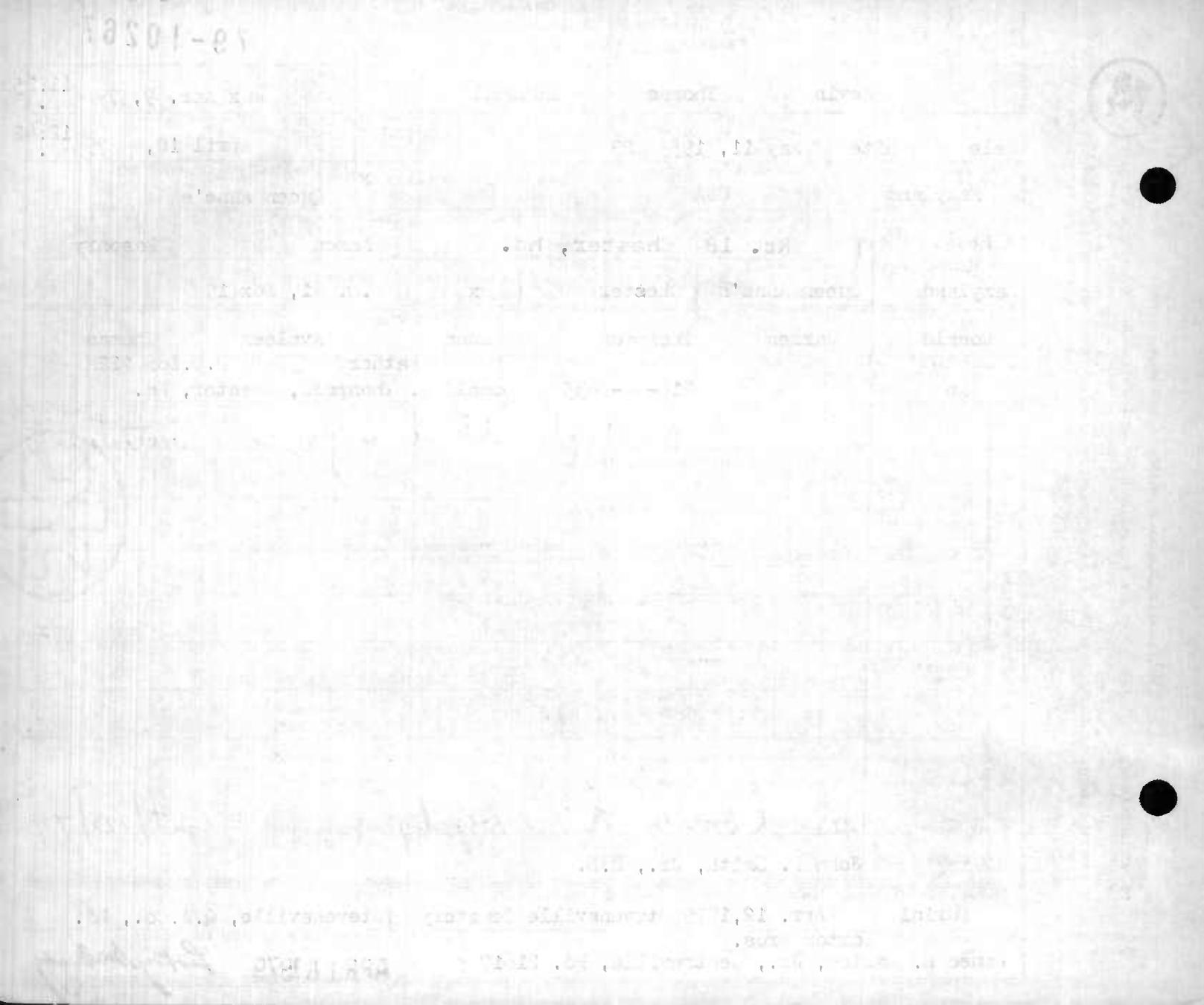
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 79-10266					
1- STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN DEATH ESTI- MATED			2b. HOUR					
			<i>BENJAMIN ARTHUR Hinson</i>						<input checked="" type="checkbox"/> MONTH 4 YEAR 7 1979			3:30 P.M.					
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS) LAST BIRTHDAY			IF UNDER 1 YR. MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN		
M			Black			March 1921			58 yrs.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH			2c. DATE PRONOUNCED DEAD			10. CITY OR TOWN OF DEATH		
Delaware			U.S.A.			<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			Queen Anne Co.			4 7 1979			Chestertown		
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Queen Anne Co., Hosp.,												Laborer					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN						2210 N. Church St.,					
Del.			New Castle			Wilm.											
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			LAST					
Benjamin A. Hinson									Margaret Hinson								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
(If Yes, Give War or Dates)									Hospital Emergency Room Records			Chestertown Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiovascular Disease</i>																	
4992 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (b) } DUE TO, OR AS A CONSEQUENCE OF (c) }																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?											
									<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <i>Robert W. Farr</i>			M.D.			TITLE (SPECIFY) <i>Deputy</i>			MEDICAL EXAMINER			DATE SIGNED 4-7-79					
EXAMINER'S NAME (TYPE OR PRINT)			ROBERT W. FARR			ADDRESS <i>Chestertown, Md. Kent Co.</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 4/13/79			23c. NAME OF CEMETERY OR CREMATORY Riverview Cem.			23d. LOCATION CITY OR TOWN Wilmington, Del., COUNTY STATE								
24. FUNERAL DIRECTOR NAME <i>Calvin Bell</i>			ADDRESS <i>909 Poplar St., Del.</i>			25a. DATE REC'D. BY REGISTRAR APR 11 1979			25b. REGISTRAR'S SIGNATURE <i>John J. Murphy</i>								

62801-2



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 79-10267					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH DAY YEAR			2b. HOUR 11:25 P.M.					
Kevin Thomas THOMPSON						<input checked="" type="checkbox"/> Apr. 9, 1979											
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR 12:42 A.M.	
Male		White		May 11, 1955		23 yrs.						April 10, 1979					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Maryland			USA			<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			Queen Anne's								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Chester, Maryland			Rt. 18 Chester, Md.			Mason			Masonry								
13a. STATE Maryland			13b. COUNTY Queen Anne's		13c. CITY OR TOWN Chester		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS R.D. #1, Box 19								
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST														
Donald Warren Thompson			Anna Avaleen Thomas														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT Father Donald W. Thompson, Chester, Md.			ADDRESS P.O. Box 722M								
No			218-64-6435														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Internal Injuries</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?											
						<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR 1:25 P.M. 4 9 79			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Auto accident											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, PARK, ETC.) Rte. 18 Chester, Md.			21f. LOCATION STREET CITY OR TOWN Chester, COUNTY QA Co., STATE Md.											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE EXAMINER'S NAME (TYPE OR PRINT)			John R. Smith, Jr., M.D.			TITLE SPECIFIED M.D. Deputy			MEDICAL EXAMINER			DATE SIGNED 4/10/79					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial Apr. 12, 1979			23c. NAME OF CEMETERY OR CREMATORIAL Stevensville Cemetery			23d. LOCATION CITY OR TOWN Stevensville, Q.A.Co., Md.								
24. FUNERAL DIRECTOR NAME James H. Barton, Jr., Centreville, Md. 21617						25a. DATE REC'D. BY REGISTRAR APR 16 1979			25b. REGISTRAR'S SIGNATURE Poston Sabady								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 79-10268							
1 - FOR STATE REGISTRAR			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			PEARLE ELIZABETH						WAGNER			APRIL 17, 1979				4 a.m.			
3. SEX <b>FEMALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>JUNE 13, 1909</b>						6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b>				IF UNDER 1 YEAR MONTHS    DAYS		IF UNDER 24 HRS HOURS    MIN	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>EASTON</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						9. BALTIMORE CITY OR COUNTY OF DEATH <b>Queen Anne</b>							
10. CITY OR TOWN OF DEATH <b>CENTREVILLE</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>CORSICA HILLS NURSING CENTER</b>			12a. USUAL OCCUPATION <b>SALESPERSON</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>FOOD</b>										
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>TALBOT</b>			13c. CITY OR TOWN <b>EASTON</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>201 DOVER STREET</b>							
14. FATHER'S NAME <b>WIELARD</b>			MIDDLE <b>TOWNSEND</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Ida. F.</b>			MIDDLE			STARKEY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214 28 3516</b>			16c. INFORMANT <b>Mrs. Jean Murphy, Cordova, Md.</b>			ADDRESS										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal Failure</b> 4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. { (b). DUE TO, OR AS A CONSEQUENCE OF N.C.V.D.; ASCVD 5 years (c). DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>4-17</b> , 19 <b>77</b> , to <b>4-17</b> , 19 <b>79</b> , that (I) (we) last saw the deceased <del>alive</del> on <b>4-17</b> , 19 <b>77</b> , and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I)(we) did (did not) view the body after death.																			
22b. SIGNATURE <i>John R. Smith, Jr.</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <b>4/17/79</b>										
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John R. Smith, Jr.</b>			22f. ADDRESS <b>Centreville, Maryland 21617</b>																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>4-20-1979</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Spring Hill</b>			23d. LOCATION CITY OR TOWN <b>Easton, Talbot, Md.</b>			COUNTY		STATE					
24. FUNERAL DIRECTOR NAME <b>Newnam Funeral Home</b>			ADDRESS <b>Easton, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>MAY 2, 1979</b>				25b. REGISTRAR'S SIGNATURE <i>Hilary McBrady</i>									

